



PTO/SB/21 (09-06)

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**TRANSMITTAL
FORM**

(to be used for all correspondence after initial filing)

Total Number of Pages in This Submission

Application Number

09/981,278

Filing Date

14 August, 2002

First Named Inventor

Wallace Matthews

Art Unit

2616

Examiner Name

Steven H.D. Nguyen

Attorney Docket Number

ENCLOSURES (Check all that apply)

<input type="checkbox"/> Fee Transmittal Form	<input type="checkbox"/> Drawing(s)	<input type="checkbox"/> After Allowance Communication to TC
<input type="checkbox"/> Fee Attached	<input type="checkbox"/> Licensing-related Papers	<input type="checkbox"/> Appeal Communication to Board of Appeals and Interferences
<input checked="" type="checkbox"/> Amendment/Reply	<input type="checkbox"/> Petition	<input type="checkbox"/> Appeal Communication to TC (Appeal Notice, Brief, Reply Brief)
<input type="checkbox"/> After Final	<input type="checkbox"/> Petition to Convert to a Provisional Application	<input type="checkbox"/> Proprietary Information
<input type="checkbox"/> Affidavits/declaration(s)	<input type="checkbox"/> Power of Attorney, Revocation Change of Correspondence Address	<input type="checkbox"/> Status Letter
<input type="checkbox"/> Extension of Time Request	<input type="checkbox"/> Terminal Disclaimer	<input checked="" type="checkbox"/> Other Enclosure(s) (please identify below):
<input type="checkbox"/> Express Abandonment Request	<input type="checkbox"/> Request for Refund	
<input type="checkbox"/> Information Disclosure Statement	<input type="checkbox"/> CD, Number of CD(s) _____	
<input type="checkbox"/> Certified Copy of Priority Document(s)	<input type="checkbox"/> Landscape Table on CD	
<input type="checkbox"/> Reply to Missing Parts/Incomplete Application	Remarks 1) Reply to non-final office action 2) corrected Patent Application	
<input type="checkbox"/> Reply to Missing Parts under 37 CFR 1.52 or 1.53		

SIGNATURE OF APPLICANT, ATTORNEY, OR AGENT

Firm Name			
Signature	Wallace Matthews		
Printed name	Wallace Matthews		
Date	Oct. 23, 2006	Reg. No.	

CERTIFICATE OF TRANSMISSION/MAILING

I hereby certify that this correspondence is being facsimile transmitted to the USPTO or deposited with the United States Postal Service with sufficient postage as first class mail in an envelope addressed to: Commissioner for Patents, P.O. Box 1450, Alexandria, VA 22313-1450 on the date shown below:

Signature	Wallace Matthews		
Typed or printed name	Wallace Matthews	Date	Oct. 23, 2006

This collection of information is required by 37 CFR 1.5. The information is required to obtain or retain a benefit by the public which is to file (and by the USPTO to process) an application. Confidentiality is governed by 35 U.S.C. 122 and 37 CFR 1.11 and 1.14. This collection is estimated to 2 hours to complete, including gathering, preparing, and submitting the completed application form to the USPTO. Time will vary depending upon the individual case. Any comments on the amount of time you require to complete this form and/or suggestions for reducing this burden, should be sent to the Chief Information Officer, U.S. Patent and Trademark Office, U.S. Department of Commerce, P.O. Box 1450, Alexandria, VA 22313-1450. DO NOT SEND FEES OR COMPLETED FORMS TO THIS ADDRESS. SEND TO: Commissioner for Patents, P.O. Box 1450, Alexandria, VA 22313-1450.

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TO: Examiner: Stephen HD Nguyen
From: Wallace Matthews

Subject: Request for extension of time to respond to office Action

Application 09/981,278

Office Action mailed 06/28/2006

I received the office action shortly after my father moved in with us. He was an invalid and required a great deal of attention. He died on Sept. 6, 2006. I am enclosing a copy of his death certificate so that you will know that this is real and not a typical excuse. I am just now catching up on the office action response. I am not a lawyer and I have had to do a lot of research to reply to Section 9 of the office action. I have the response almost complete and am mailing it along with this request. By the time it gets there it will be slightly more than a month late.

I am an individual inventor. I have not had to deal with a patent without an experienced patent attorney before and it is proving to be a daunting task. Please be patient with my not knowing the details and forms to use.

Wallace Matthews
Wallace Matthews

PS – if e-mail would be better, I can be reached through my wife's e-mail account. ileenmatthews@comcast.net

(INSTRUCTIONS ON REVERSE SIDE)



The Commonwealth of Massachusetts

STANDARD CERTIFICATE OF DEATH
REGISTRY OF VITAL RECORDS AND STATISTICS

000262

FOR USE BY
PHYSICIANS AND
MEDICAL EXAMINERS

REGISTERED NUMBER

STATE USE ONLY

STATE USE ONLY
4c Hosp
5 Type
6 Hosp Race
10 Age
15 Resid
15 Out-State
23 Disap
31-32 Autop
34 Manner
35c Work Inj
35f Place
38-37 Cert
40a Pron

DECEDENT

INFORMANT

DISPOSITION

CERTIFIER

DECEDENT - NAME		FIRST	MIDDLE	LAST	SEX	DATE OF DEATH (Mo., Day, Yr.)
Wallace		F.	Matthews		M	September 6, 2006
PLACE OF DEATH (City/Town):		COUNTY OF DEATH	HOSPITAL OR OTHER INSTITUTION - Name (If not in either, give street and number)			
4a Milford		4b Worcester	4c Milford Regional Medical Center			
PLACE OF DEATH (Check only one):		OTHER		SOCIAL SECURITY NUMBER		IF US WAR VETERAN SPECIFY WAR
HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		<input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		6 [REDACTED]		7 WWII
WAS DECEDENT OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> NO <input type="checkbox"/> YES		RACE (e.g. White, Black, American Indian, etc.) (Specify)		DECEDENT'S EDUCATION (Highest Grade Completed)		
8a Specify:		8b White		8 12		
AGE - Last Birthday (Yrs.)	UNDER 1 YEAR	UNDER 1 DAY	DATE OF BIRTH (Mo., Day, Yr.)	BIRTHPLACE (City and State or Foreign Country)		
85	MOS	DAYS	100 July 16, 1921	11 Jacksonville, FL		
MARRIED, NEVER MARRIED		LAST SPOUSE (If wife, give maiden name)		USUAL OCCUPATION (Prior - If Retired)		KIND OF BUSINESS OR INDUSTRY
12 Married		Sarah Weaver		14a Laborer		14b Mining Company
RESIDENCE - NO. & ST., CITY/TOWN, COUNTY, STATE/COUNTRY						ZIP CODE
15a 950 Lake Lotela Drive, Avon Park, Highlands Co., FL						33826
FATHER - FULL NAME		STATE OF BIRTH (If not in US, name country)	MOTHER - NAME (GIVEN) (MAIDEN)	STATE OF BIRTH (If not in US, name country)		
16 Joseph Matthews		17 GA	18 Unknown Bishop	19 GA		
INFORMANT'S NAME		MAILING ADDRESS - NO. & ST., CITY/TOWN, STATE, ZIP CODE				RELATIONSHIP
20 Sarah W. Matthews		21 P.O. Box 985, Avon Park, FL 33826				22 Wife
23 METHOD OF IMMEDIATE DISPOSITION		FUNERAL SERVICE LICENSEE OR OTHER DESIGNEE		LICENSE #		
<input type="checkbox"/> BURIAL <input checked="" type="checkbox"/> CREMATION <input type="checkbox"/> ENTOMBMENT <input type="checkbox"/> REMOVAL FROM STATE <input type="checkbox"/> DONATION <input type="checkbox"/> OTH. SPEC.		24 James R. Buma		25 6460		
PLACE OF DISPOSITION (Name of Cemetery, Crematory or other)		LOCATION (City/Town, State)				
26a Rural Cemetery & Crematory		26b Worcester, MA				
DATE OF DISPOSITION (Mo., Day, Yr.)		NAME AND ADDRESS OF FACILITY OR OTHER DESIGNEE				
27 Sept. 12, 2006		28a Buma-Sargeant Funeral Home, 42 Congress St., Milford, MA 01757				
PART I - Enter the diseases, injuries, or complications that caused the death. Do not use only the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line (a through d) PRINT OR TYPE LEGIBLY.						Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death)						
a. Respiratory Failure						hours
b. Mucous Plugging						hours
c. Central Cord Syndrome						days
d.						
PART II - Other significant conditions contributing to death but not resulting in underlying cause given in Part I.						
30 MED. EXAM. NOTIFIED? (Yes or No)						31 WAS AUTOPSY PERFORMED? (Yes or No)
30 No						31 No
34 MANNER OF DEATH		DATE OF INJURY (Mo., Day, Yr.)		TIME OF INJURY		INJURY AT WORK (Yes or No)
<input checked="" type="checkbox"/> NATURAL <input type="checkbox"/> HOMICIDE <input type="checkbox"/> COULD NOT BE DETERMINED		35a		35b		35c
33 <input type="checkbox"/> ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> PENDING INVESTIGATION		35a		35b		35c
DESCRIBE HOW INJURY OCCURRED		PLACE OF INJURY (At home, farm, street, factory, office bldg., etc.) Specify		LOCATION (No. & St., City/Town, State)		
35d		35e		35f		
36a To the best of my knowledge, death occurred at the time, date, and place and due to the cause(s) stated.		36b DATE SIGNED (Mo., Day, Yr.)		36c HOUR OF DEATH		36d
36a September 6, 2006		36b September 6, 2006		36c 6:30 PM		36d
NAME OF ATTENDING PHYSICIAN IF NOT CERTIFIER		37a On the basis of examination and/or investigation in my opinion death occurred at the time, date, and place and due to the cause(s) stated.		37b DATE SIGNED (Mo., Day, Yr.)		
36d Dr. Mark Skiba		37a		37b		
NAME AND ADDRESS OF CERTIFYING PHYSICIAN OR MEDICAL EXAMINER (Type or Print)		37c PRONOUNCED DEAD (Mo., Day, Yr.)		37d		
36d Andrew Popelka MD, 14 Prospect Street, Milford, MA 01757		37c		37d		
38 WAS THERE A PRONOUNCEMENT FORM? (Yes or No)		IF YES, DATE PRONOUNCED		IF YES, TIME PRONOUNCED		40d NAME OF PRONOUNCER
38 NO		40b		40c		40d
DATE BURIAL PERMIT ISSUED		RECEIVED IN BOSTON ONLY OF		DATE OF RECORD		
39 SEPTEMBER 7, 2006		39		43		
SIGNATURE OF HEALTH AGENT		CLERK'S SIGNATURE		DATE OF RECORD		
41 Paul Mazzucchelli		42 Joseph Arcudi		43 Sept 7, 2006		

Pronouncement of Death
Form (R-302) on File: ☐PERMANENT
BLACK INK ONLY

R-301-05

A TRUE COPY OF THE RECORD
ATTEST: Joseph Arcudi
MILFORD TOWN CLERK

BEST AVAILABLE COPY